STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005605	A. BUILDING: _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHITE OAK SURGERY CENTER LLC	1950 45TH STREET MUNSTER, IN 46321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS JCAHO Surveyor: 34586 Facility Number: 005605 Type of Survey: State Licensure Off Site JCAHO Accreditation Survey Date of JCAHO On Site Survey - Hospital full survey 7/15-16/2014 Date of ISDH off site review -10/20/2014 Reviewer/Surveyor -Kerry Sawin RN, PHNS Based on review of the 7/15-16/ 2014 JCAHO Accreditation Survey Report, it has been determined that White Oak Surgery Center meets the requirements for Hospital Licensure in Indiana for 2014.	S 000		